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Choreography and Performance with Deaf Adults Who Have Mental Illness: Culturally Affirmative Participatory Research

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CHOREOGRAPHY AND PERFORMANCE WITH DEAF ADULTS WHO HAVE MENTAL ILLNESS:

CULTURALLY AFFIRMATIVE PARTICIPATORY RESEARCH

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Abstract

Dance/movement therapy (DMT) techniques—particularly choreography and performance techniques—have not been well-researched with Deaf adults who have mental illness. This study investigated the use of DMT, choreography, and performance techniques with Deaf adults with severe and chronic mental illness through participatory artistic inquiry. Primary research questions addressed pragmatic matters of participatory artistic inquiry: What aesthetic choices will the co-researchers make in the dance-making process? How does the researcher provide structure and incorporate her experience as a choreographer without overshadowing the contributions of the co-researchers? Broader philosophical research questions included: How do choreography and performance techniques impact this population's well-being? How does the use of American Sign Language and other culturally affirmative practices support the dance-making process? Data was gathered by engaging the participants as co-researchers, involving them in the development of research protocol, data collection, data analysis, and the presentation of the research findings. Findings indicated that engaging in a choreographic process addressed the co-researchers' preexisting treatment goals, provided opportunities for transferring skills learned in previous DMT groups, and empowered the co-researchers to incorporate performance techniques common to Deaf culture. The final choreographic product was presented at the site where the co-researchers receive mental health services and shared with the larger mental health care community through a digital video recording and a publishable journal article.

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Introduction

Like many dance/movement therapists, I am a dancer, choreographer, and performer. Throughout my dance career, I have experienced the psychological benefits of crafting and performing my own work for an audience. These experiences were part of what inspired me to become a dance/movement therapist. As I began my dance/movement therapy (DMT) training, I knew I wanted to work with Deaf individuals. My twin brother is Deaf, and I have grown up being familiar with *American Sign Language* (ASL, see Appendix A) and Deaf culture. My brother and I spent our formative years performing in a theatre and dance company that included Deaf, hearing, and hard-of-hearing members. This exposed me to more of Deaf culture and Deaf arts. Deaf people in the United States are a linguistic minority who share ASL as a primary language and make up a community that is culturally distinct from the hearing population (Glickman & Gulati, 2003; Moore & Levitan, 1993; Williams & Abeles, 2004). A note on standard usage: the capital letter "D" indicates cultural Deafness, while a lower case "d" notes only audiological capacity without reference to membership in a cultural group (see Appendix A). This convention will be ascribed to throughout this article.

During my DMT training, I worked as an intern in a day program serving deaf, hearing, and hard-of-hearing adults with severe and chronic mental illness. Throughout my internship, I led DMT sessions with a small group of deaf and hard-of-hearing clients. They responded well to interventions that involved choreography and enjoyed asking staff members to watch the dances that they would create during our sessions. Their positive responses to DMT groups that involved choreography and performance made me curious about the therapeutic effects of such techniques on this population. I also felt excited about the possibilities of working with

performing arts and Deaf culture in a way that I had not been able to do since leaving my childhood theatre and dance company after high school.

The purpose of this study was to investigate the use of DMT, choreography, and performance techniques with Deaf adults with *severe and chronic mental illness* (see Appendix A) through *artistic inquiry* (see Appendix A). I engaged in *participatory research* (see Appendix A) with the study's participants—who will henceforth be referred to as "co-researchers" (Schneider et al., 2004, p. 564)—involving them in the development of research protocol, data collection, data analysis, and the presentation of research findings. My aim was to give the co-researchers a creative space in which to empower themselves and share an artistic message within their service setting.

Primary research questions addressed pragmatic matters of participatory artistic inquiry: What aesthetic choices would the co-researchers make in the dance-making process? How would the researcher provide structure and incorporate her experience as a choreographer without overshadowing the contributions of the co-researchers? Broader philosophical research questions include: How would the use of ASL and other culturally affirmative practices support the dance-making process? How would choreography and performance techniques impact this population's well-being?

This research has the potential to make a significant contribution to the literature on DMT with deaf adults with severe and chronic mental illness. It will be of value to service providers working with this population because this subject has not been well-researched thus far. Various authors have observed the benefits of dance performance for the deaf (Benari, 1995; Reber & Sherrill, 1981; Sherman, 1997; Wisher, 1972). However, no detailed accounts of enacting a choreographic process have yet been published, and none of the existing descriptions come from

the field of DMT. This study fills this gap in the research, contributing the first work of research using DMT techniques with deaf adults in more than a decade (Klibanow, 2000), and the first use of artistic inquiry by a dance/movement therapist working with this population.

Literature Review

It is largely recognized that mental health care services for the deaf are inadequate (Black & Glickman, 2006; DeVinney, 2003; Glickman, 2003; Glickman & Gulati, 2003; Williams & Abeles, 2004). Communication barriers, discrimination, cultural misunderstandings, paucity of available services, untrained or under-trained service providers, and lack of appropriate accommodations often render services inaccessible to deaf and hard-of-hearing people with mental illness. A variety of treatment approaches have been researched and implemented in an attempt to shift this trend and meet the precise needs of this population. One such need is the importance of visual and nonverbal communication (Glickman, 2003; Glickman & Gulati, 2003; Trikakis, Curci, & Strom, 2003). With this in mind, is DMT, which emphasizes nonverbal communication through body movement, an appropriate treatment modality to meet communication needs in a psychotherapeutic context?

This article draws upon literature in the fields of mental health and deafness, dance, performance studies, Deaf studies, and DMT. Out of the wealth of information available about mental health care for the deaf, researchers have placed particular focus on sources that relate to mental illness in deaf adults and the place of language and culture in mental health treatment. The body of literature about dance with the deaf is small, and focuses on the social, emotional, and physical benefits of dance for deaf people across the lifespan, as well how sign language may be incorporated into both dance classes and choreography. DMT with deaf adults is under-researched, but the existing literature seems to focus on the use of sign language, the importance of nonverbal communication, and the contributions that movement observation and assessment can make to the larger field of mental health care with the deaf population.

Mental Health Care for the Deaf

Cultural affirmation. A review of the literature reveals a growing understanding of the importance of culture in the delivery of mental health services to Deaf individuals. In the United States, Deaf people make up a linguistic minority—using ASL as their primary language—who are culturally distinct from hearing people (Glickman & Gulati, 2003; Moore & Levitan, 1993; Williams & Abeles, 2004). *Cultural affirmation* (see Appendix A) is a crucial element of psychotherapy with these clients, who have often experienced oppression and discrimination by the majority hearing culture. Glickman and Gulati (2003) stated that providing culturally affirmative services "includes having cultural competence, relevant self-awareness, and special knowledge and skills" (p. xi). This is a higher standard for a clinician to meet than accessibility (Glickman, 2003). This is not to say that accessibility is an unimportant component of mental health care for deaf individuals. Janet DeVinney (2003), a late-deafened woman, was denied the accommodations legally owed to her by laws such as the Americans with Disabilities Act (ADA) while receiving inpatient psychiatric treatment for severe depression. She did not receive sufficient access to a TTY—a type-based communication device that uses telephone lines—or to a competent ASL interpreter in a timely manner. DeVinney was, therefore, unable to communicate with anyone outside the hospital or participate in her own treatment planning or even understand basic procedures such as how to receive her medication. Her case clearly illustrates the traumatic consequences of inaccessible care.

However, Glickman (2003) contended that merely providing ASL interpreters and other accommodations under the ADA is insufficient. Deaf people have historically been discriminated against, oppressed, and even abused by the majority hearing population. ASL and other aspects of cultural Deafness were forbidden in many deaf schools in favor of forcing speech and *speech-reading*—often called reading lips—is a complex and sometimes exhausting skill that requires

analyzing the mouth, eyes, eyebrows, facial expression, and associated cues such as objects and the surrounding environment in order to discern the speaker's message (see Appendix A). Deaf people have been viewed as unintelligent and immature. But the most damaging aspect of oppression of the deaf, he stated, is "disempowering them around communication, resulting in communication isolation" (Glickman, 2003, p. 3). Glickman argued that cultural affirmation is a necessary component of effective psychotherapy with Deaf clients; to discount Deaf culture is to perpetuate the oppression deaf people have experienced and repeat the same offenses that have contributed to the issues a deaf person faces. Without culturally affirmative treatment, Glickman asserted that the experience of psychotherapy itself can be traumatic. Hearing therapists act in "ignorant, uninformed, and biased [ways]"—reenacting past negative experiences with hearing people (p. 7). Therefore, as the deaf clients attempt to explain their psychological experiences, they "can't develop trust, the foundation of mental health treatment, in an environment where people don't speak their language, don't understand their world, don't validate their experiences, and *don't know what they don't know*" (p. 7). Denying a Deaf person culturally affirmative mental health care services can result in a re-traumatizing experience, negating opportunities for healing and exacerbating existing mental health problems.

Language deprivation. In addition to providing culturally affirmative services, clinicians who work with Deaf individuals must understand the role language plays in a Deaf person's development. Gulati (2003) described the importance of language acquisition for a developing brain. He reported that a "critical period" (pp. 42-43) exists within which a child must be exposed to a useable language if they are to be capable of learning any language fluently, noting that controversy exists about when the critical period ends. However, first language exposure after approximately age six is generally considered to result in non-fluent

ASL by the Deaf community. *Language deprivation* (see Appendix A) appears to be particularly common among deaf adults with mental illness. Black and Glickman (2006)—highly trained professionals in the field of mental health and deafness—found that, when assessed by a Deaf communications specialist, 75% of patients on an all-deaf psychiatric until were classified as "language deprived" (pp. 314-315).

Gulati (2003) stated that this critical period implies the greatest developmental risk to deaf children—that "those with first exposure to usable language *after* very early childhood develop permanent cognitive damage and permanent language deficits" (p. 43). Because the majority of deaf children are born to hearing parents who cannot teach them sign language during this critical period, deaf people are at risk of failing to acquire fluent language and experiencing the difficulties that follow. Social skills, emotional development, and educational and vocational success are all highly reliant on language. Most significantly, it appears that the development of the brain's internal thinking language depends on exposure to grammatical language. Without a capacity for grammatical language, this internal thinking language cannot promote more complex intellectual functions, such as abstract thought. The consequences of language deprivation influence the way deaf adults present in mental health service settings.

Clinical presentation. Not all deaf adults who experience language deprivation will develop mental health problems. Among those who only have mild-to-moderate language deprivation, the consequences of language deprivation will likely not be as severe (Gulati, 2003). However, deaf adults who are unable to develop an internal thinking language tend to display various common features when they present in a mental health setting:

1. Show verbal and cognitive deficits despite normal performance IQ,

2. Become overwhelmed, confused, or obsessed with the complexities and demands of the abstract world, such as medical, financial, legal, or psychiatric,
3. Appear to have a thought disorder,
4. Appear lethargic or demented despite presumably normal intelligence,
5. Lack insight into psychological processes,
6. Lack social rules (e.g., about normal sexual behavior),
7. Have very poor world knowledge, such as lack of knowledge of personal health care, resulting in increased susceptibility to illnesses, and potentially worsening their course,
8. Show a wide variety of social and emotional deficits that result in a markedly reduced quality of life,
9. Be unable to answer basic questions about their own lives. In addition to lacking information, they may have difficulty with time sense, narrative sequence, and cause and effect. (pp. 63-64)

These consequences may also be seen in deaf adults with mild-to-moderate language deprivation to varying degrees. Common psychiatric symptoms among deaf adults include psychosis, affective illness, aggression, and attention deficits (Gulati, 2003), which may be components of mood and anxiety disorders, psychotic disorders, personality disorders, substance abuse disorders, and developmental delays (Black & Glickman, 2006). Black and Glickman's (2006) findings regarding the prevalence of language deprivation among deaf inpatients may indicate that language deprivation profoundly impacts the mental health of deaf people.

Deaf and hard-of-hearing people are also more susceptible to abuse and neglect, which may result in post-traumatic stress disorder (PTSD). PTSD is perhaps more widespread among

deaf adults than has been previously estimated. Black and Glickman (2006) assessed patients on an all-deaf psychiatric unit and found that more than half reported a history of trauma and abuse. One third of these patients met the criteria for PTSD.

Nonverbal Treatment Approaches

In addition to the psychological implications of language deprivation, communication and language challenges abound when working with deaf adults who have mental illness. The majority of mental health care providers is hearing and has little-to-no knowledge of the deaf population, their most commonly-used communication methods, or Deaf culture. Thus, language and communication barriers between the deaf client and the hearing therapist create a significant treatment barrier. This problem is only compounded by the scarcity of well-trained ASL interpreters and the fact that miscommunications can still occur even with an interpreter present (Paijmans, Cromwell, & Austen, 2006; Williams & Abeles, 2004). Mental health assessments such as mental status examinations, written questionnaires, and diagnostic inventories have been developed with and tested on hearing, English-fluent patients (Glickman, 2007; Paijmans, Cromwell, & Austen, 2006).

Given these challenges, some authors have suggested the use of nonverbal treatment approaches in working with this population. Trikakis, Curci, and Strom (2003), nurses on a deaf-only inpatient psychiatric unit, have utilized an approach they call Sensory Movement Interventions (SMI) to teach their patients skills for more effective living and encourage more meaningful engagement in their own mental health treatment. SMI, a treatment based on sensory integration theory, aims to help its users "attain a level of calm alertness that is optimal for self-awareness and learning" (p. 5). It does not require highly abstract reasoning, verbal communication, or the ability to process written information. Rather, it relies on organizing

sensory-neurological patterns for optimal functioning within the environment. Trikakis et al. argued that SMI is culturally affirmative, making use of Deaf persons' preferred modes of visual and kinesthetic communication, and appropriate for language deprived individuals.

In their report of their observations on the deaf unit, Trikakis et al. (2003) noted that deaf patients who have participated in ongoing SMI treatment are more able to control emotional outbursts, better able to interact positively with the environment, more receptive to feedback from others, and more self-aware. SMI incorporates all of the senses: vision, hearing (for those patients who have usable hearing), taste, smell, touch, and even movement. Trikakis et al. observed that touch and movement were the most effective types of activities for promoting self-regulation and change among their patients. Touch and movement can calm or arouse; action that engages the somatosensory, vestibular, and/or proprioceptive systems can be used to achieve and maintain states of emotional regulation.

Dr. Luther D. Robinson (1973) asserted that the creative arts therapies are an integral part of treatment for deaf adults with mental illness. He established a program for deaf psychiatric patients at St. Elizabeth's Hospital in Washington, D.C. in 1963. In his nearly four-decade-old article, he briefly described this groundbreaking mental health program. Robinson observed that expression through "activity therapies" such as creative drama, psychodrama, role-play, DMT, visual art, and recreational activities provided important outlets without relying on methods of verbal communication (p. 41). There is a dearth of more recent literature about mental health treatment settings for deaf adults with mental illness—although Brucker (2007) and Hoggard (2006) have elaborated upon the psychosocial benefits of art therapy with this population. However, creative arts therapists have described their work with similar populations. For example, art therapy has been considered beneficial for deaf emerging adults with adjustment

issues (Eldredge & Carrigan, 1992), as has psychodrama with deaf adolescents who have emotional and behavioral problems (Batory, 1994).

Dance and the Deaf

Professionals outside the mental health care field have also noted the benefits of movement for the normal neurotic deaf person. The late Dr. Peter Wisher believed that ASL is expressive nonverbal communication through movement (Levy, 2005; Wisher, 1972). To this end, he established the dance education program at Gallaudet University, America's only Deaf liberal arts institution. Wisher (1972) wrote, "Dance should not be considered an end in itself but as an effective means of assisting the deaf individual to live in harmony with himself, the deaf, and the hearing" (p. 4). In working with his students, he observed that dance serves the total personality and benefits deaf young adults intellectually, emotionally, physically, and socially. He found dance to be therapeutic, facilitating the externalization of "feelings, beliefs, and fears" (Wisher, 1972, p. 4). Although the language Wisher uses to describe the young deaf adults with which he worked is, at times, outmoded and patronizing, his assertions regarding the positive effects of dance with this population appear genuine.

Outside of Wisher's work, little has been written about dance and deaf adults. Benari (1995), however, explained the benefits of dance for deaf children in her book *Inner Rhythm: Dance Training for the Deaf*. She taught dance classes to deaf and hard-of-hearing schoolchildren in the United Kingdom. Her classes involved breathing techniques, rhythmic activity, creative movement games, storytelling, sign language in instruction and as a creative tool, and the development of physical skills such as jumping, turning, balance, and locomotion. Through her extensive work with deaf children, she found that dance promoted self-expression, spatial awareness, awareness of self and other, sociability, self-discipline, communication,

imagination, and focused attention. Contrary to what she had been told by teachers of the deaf, Benari observed that deaf children have strong recall memories. She was impressed by their ability to recall movement —performed by others and by themselves—and replicate "complete dance sequences," including the "quality, dynamics, and emotional content" of the movement (p. xx).

Benari (1995) theorized that the success of her dance classes could be attributed to the intrinsic characteristics of a deaf child. She posited that "[because] the deaf use their bodies to communicate as dancers also do, it is logical to assume that the deaf can dance at least as expressively as hearing people, and probably more so" (p. xv). Dance/movement therapists such as Cohen (1990) and Oosterhaus (1985) also echoed this sentiment.

Sherman's (1997) case study evaluated a program designed to foster intergenerational relationships between 10 Deaf elders and 10 deaf/hard-of-hearing children using dance. Her dance instruction included two phases: five weekly age-segregated dance classes followed by ten weekly, integrated dance classes. The classes were conducted in ASL and appear, from a brief description, to have included a warm-up, improvisation, circular and linear formations, symbolism, and imagery. Sherman performed qualitative analyses of observational and interview data to reach her conclusions. The study found that dance is an effective technique for fostering interaction between the two age groups, who are often isolated. The children learned more about the needs of aging adults and about Deaf culture. The Deaf elders experienced increased nurturance and expressivity in serving as grandparent-role models for the children. Sherman argued that dance is a particularly relevant medium for encouraging intergenerational relations in the deaf population because their primary communication modality, ASL, involves

communicating through their bodies. Her study clearly illustrates the ways in which dance and movement can benefit deaf individuals.

In addition to the qualitative observations of Wisher (1972), Benari (1995), and Sherman (1997), some empirical evidence exists regarding the positive outcomes of dance in the deaf population. Reber and Sherrill (1981) performed an experimental study on the creative thinking and dance/movement skills of a small sample of deaf and hard-of-hearing male and female youth ages 9-14. They collected data from 45-minute creative movement sessions that occurred twice weekly for ten weeks. Sessions focused on basic movement skills, nonverbal communication through dance/movement, and thinking creatively in dance improvisation and composition. Reber and Sherrill concluded that creative dance/movement instruction is an effective means of improving creative thinking abilities and dance/movement skills of her participants. Specifically, they observed an increase in elaboration and originality among deaf youth when compared to the control group.

Dance/Movement Therapy

The benefits of dance and movement with the deaf population have been translated to clinical settings (Cohen, 1990; Oosterhous, 1985; Robinson, 1973).Although the literature is scarce in this area, it is clear that DMT has been utilized as a treatment modality for deaf adults with mental illness. Dance/movement therapists have made significant contributions investigating the use of the discipline with deaf children (Bond, 1992; Comyn, 1993; Miller, 1986; Schilleschi, 1990; Strickler, 1995); review of that literature is beyond the scope of this discussion.

Robinson (1973) briefly noted the historical use of DMT as a treatment for mental illness on the deaf unit of St. Elizabeth's Hospital. He elaborated upon its benefits for this population,

stating, “Dance therapy permits deaf patients to use body movement and rhythm as a means of communication” (p. 41). In this article, Robinson highlighted the isolation often experienced by deaf adults with mental illness—whether due to communication barriers, inadequate language skills, or psychiatric symptoms—and spoke to the positive effects of DMT in combating this isolation. DMT at St. Elizabeth’s gave deaf patients the opportunity to socialize with both deaf and hearing people, communicating through rhythm and other nonverbal means of expression.

Cohen (1990) expanded upon Robinson’s argument, presenting a theoretical rationale for the use of DMT when providing psychotherapy for deaf adults with mental illness. Offering his opinion as a dance/movement therapist, he argued that body movement comprises a rich source of intrapsychic and emotional data about a patient. Dance/movement therapists collect these data through movement observation systems such as Laban Movement Analysis. This information is particularly salient in the context of the communication difficulties (and consequences of language deprivation) inherent in the field of mental health and deafness. Cohen also promoted nonverbal movement behaviors as a valuable method of communication between hearing mental health professionals and deaf mental health consumers who utilize different language systems. Nonverbal communication, he posits, “can make the difference between establishing a working relationship and providing effective therapy or not. Body movements are necessarily expressive and for this reason are useful for communication purposes” (p. 4). In addition to facilitating assessment and communication during psychotherapy, DMT provides the deaf client with an opportunity for emotional expression. Useful techniques appear to include the use of imagery, props, and drums to visually cue a shared group rhythm (Cohen, 1990; Oosterhous, 1985).

Oosterhous (1985) completed a master’s thesis describing her use of ASL in facilitating DMT with deaf adults in a psychiatric setting. Her work took place on the same unit founded by

Robinson at St. Elizabeth's hospital. Like many other clinicians working with this population (Glickman, 2003; Gulati, 2003; Williams & Abeles, 2004), she stressed the importance of ASL fluency in the therapist. This is both a practical concern regarding ease of communication and a matter of importance regarding the development of the therapeutic relationship. Oosterhous demonstrated some culturally affirmative practices (Glickman, 2003; Gulati, 2003), asserting that demonstrating competence in ASL shows respect for Deaf culture and engenders a sense of trust between the Deaf client and the therapist. She also considered ASL to be integral to developing therapeutic interventions with Deaf patients. Noting the similarities between DMT and ASL (i.e., expressive movement-based communication utilizing both verbal and nonverbal means), Oosterhous (1985) argued that when both are integrated into a session, "dance/movement therapy with the deaf is the natural evolution of a patient's movement impulse into self-expression" (p. 77). She offered a few concrete examples of how to utilize ASL in developing movement interventions, such as reflecting ASL expression of emotions throughout the entire body, elaborating upon the movement qualities of a particular sign, and creating "sign dances" using abstracted signs extended from the hands into the whole body (Oosterhous, 1985, p. 83).

Choreography, Performance, and Performance as Therapy

As many dance/movement therapists know from personal experience, the acts of creating, rehearsing, and performing can be therapeutic (i.e., personally cathartic). However, *performance as therapy* (PAT, see Appendix A) has not been widely researched in the field of DMT, and no studies have been conducted with deaf individuals. Gates (2006) defined performance as therapy as "dance creation for the purposes of performance involving dance/movement therapy techniques within a therapeutic environment" (p. 5). In three case studies involving a total of 18

normal neurotic young adult women, she found that the therapeutic environment was a crucial part of performance as therapy. For Gates, the therapeutic environment consists of "trust, support, and validation;" "connection to self and others;" and "safety to feel vulnerable" (p. 5). Gates's participants expressed that trusting and feeling supported by the facilitator and the other performers during the rehearsal process was necessary in order to share and process emotional content while choreographing a piece. These feelings of trust and support made her participants feel validated. Gates argued that a lack of trust, support, and validation might hinder the therapeutic process. Her participants also felt that setting and performing choreography increased their connection to and understanding of themselves and the other group members. While choreographing, rehearsing, and performing, participants in all of the case studies described feeling vulnerable in divulging deeply personal topics. However, Gates found that when this vulnerability was supported and could be verbally processed within the therapeutic environment, it held the capacity for growth, self-reflection, and self-awareness in her participants. Creating and performing a dance within the context of the therapeutic environment, which is comprised of these three elements, can promote personal growth and change (Gates, 2006).

Pavelka (2007) also stressed the importance of the therapeutic environment in PAT. In a choreography and performance-based artistic inquiry with two other dancers, she found that being "witnessed and validated" by others allowed her and her co-investigators to share parts of themselves that they would not have otherwise revealed (p. 2). Due to their preexisting relationship, the three dancers were able to support each other throughout the PAT process and, thus, organically create authentic movement in a safe space. Pavelka found that, as a result of the PAT process, she and her co-investigators recognized and investigated suppressed emotions, used each other's support to "[develop] deeper self-connections," became motivated to work

through "inner conflicts," developed "true empathy" with each other, and built upon this empathy to "embody and achieve intrapersonal transformations" (p. 31).

Pavelka (2007) also acknowledged the challenges inherent in acting as both a dancer/choreographer and a dance/movement therapist charged with holding the therapeutic environment. She noted the difficulty of engaging both her skills as a clinician and her artistic preferences in the choreographic process, stating, "I had to find the balance in preserving the purity and integrity of the raw movement material and creating an aesthetically pleasing dance which reflected the story of our process" (p. 46). Pavelka seemed to indicate that it may be difficult for a trained choreographer turned dance/movement therapist to let go of his or her aesthetic values in order to preserve the authenticity and therapeutic power of the movement generated in the dance-making process. However, it is clear that it is important for the clinician to remain aware of these two, sometimes conflicting, roles when facilitating PAT.

Goldman and Larsen (2011) created a specific framework for engaging in PAT. They developed this framework based on their experiences teaching a course in PAT in the DMT program at Columbia College Chicago. For Goldman and Larsen, PAT is structured in a four-step process: request, claim, promise, and execute. In the request stage, the performer finds "an inner impulse to move and then [allows] the body to be moved by the impulse" (p. 6). In the claim stage, the performer accepts this impulse and lets it develop into repeatable, choreographed movement. In the promise stage, the performer commits to the intention and meaning behind the choreography and to the other performers in the piece. The group resolves any conflicts that have arisen and promises to work together to create a piece. In the execute stage, the performers create and perform a piece based on their experiences from the request, claim, and promise stages. Goldman and Larsen believed that this PAT framework is a process of change that nourishes the

"creative selves [of] dancers, dance therapists, and human beings" (p. 9). This emphasis on the transformative power of choreography and performance aligns with Gates's (2006) and Pavelka's (2007) findings.

The majority of scholarly writing and research about PAT has been conducted with normal neurotic adults. However, some dance/movement therapists have applied PAT techniques in their work with other populations. Cook (2008) used PAT in her work with a group of nine adolescents with mild to moderate developmental delays. Cook realized that her participants' cognitive abilities made it difficult for them to choreograph a piece based on their own experiences. Instead, she became the choreographer and teacher, developing a dance based on the movements her participants presented in DMT group, which was then performed twice: once for a group of strangers at Columbia College Chicago and once for their peers and teachers at the school they attended. Cook found that engaging in the PAT process increased her participants' verbal and non-verbal communication skills—particularly in communicating their emotions. The participants increased their ability to form relationships with each other through PAT. Cook also observed that her participants demonstrated increased focus, attention span, and memory during the rehearsal process. Finally, Cook believed that engaging in PAT reduced participants' feelings of shame about their disabilities. Similarly to Cook, Duggan (1995) used choreography and performance in her role as a dance/movement therapist working with adolescents with learning disorders. Duggan found that the process of choreographing and performing their own work "affected their lives positively, enhancing their sense of competence and self-esteem and developing their ability to relate meaningfully and cooperatively with others" (p. 240). Thus, PAT has not only benefited normal neurotic adults, but also populations that dance/movement therapists may work with in therapeutic settings.

In addition to these contemporary practitioners using PAT, there is ample evidence that Marian Chace, founding mother of DMT, incorporated choreography and performance as part of her practice (Chace, 1954/1993c, 1955/1993b, 1958/1993a, 1958/1993d; Johnson, 1993). While working at St. Elizabeth's Hospital in Washington, D.C., Chace facilitated musical productions with adult psychiatric patients. These musicals, which incorporated theatre and dance, were initiated and created by the patients, who wished to share their experiences of hospital life and mental illness. Foreshadowing the work of later dance/movement therapists working in PAT frameworks, Chace (1954/1993c, 1955/1993b, 1958/1993a, 1958/1993d; Johnson, 1993) found that crafting and performing personal material had many benefits for her patients: increase in self-awareness, self-confidence, self-respect, responsibility, and authentic expression of both movement and emotion; gaining distance from the difficulties of living with mental illness; working with peers towards a common goal; and receiving support from peers. She believed that developing these skills by creating a performance piece within the hospital setting would transfer to her patients' lives upon discharge (Chace, 1955/1993b, 1958/1993d).

Like Gates (2006) and Pavelka (2007), Chace (1954/1993c, 1958/1993a, 1958/1993d) believed that these positive effects must be contained within a therapeutic environment, particularly through a preexisting therapeutic relationship with the group facilitator and a supportive relationship with peers. She also described the challenges of facilitating a therapeutically-oriented performance. Facilitators must manage group dynamics as disagreements arise without imposing their opinions on the group (Chace, 1954/1993c, 1958/1993a, 1958/1993d), keep group members focused during the rehearsal process (Chace, 1955/1993b, 1958/1993d), and also manage any of their own feelings of doubt about the success and/or artistic integrity of the performance (Chace, 1958/1993d). These observations are

comparable to the findings of contemporary dance/movement therapists who use PAT techniques with their clients (Cook, 2008; Duggan, 1995; Gates, 2006; Pavelka, 2007).

Summary

Appropriate and effective mental health care for deaf adults with mental illness requires a culturally affirmative approach, including the fluent use of ASL by service providers. Hearing dance/movement therapists have suggested that DMT is an inherently culturally affirmative approach, citing the similarities between ASL and DMT: nonverbal communication, expressive movement, etc. Culturally affirmative treatment also involves taking into account the effects of language deprivation and poor language comprehension on this population. As a solution to this pressing clinical problem, several nonverbal treatment approaches have been identified, including DMT. The effectiveness of DMT for deaf adults with mental illness is under-researched, and there is no literature exploring choreography and performance as a possible therapeutic intervention. In this study, I hoped to address this gap in the literature. I investigated the use of choreography and performance with Deaf adults with mental illness, guided by the following research questions: What aesthetic choices would the co-researchers make in the dance-making process? How would the researcher provide structure and incorporate her experience as a choreographer without overshadowing the contributions of the co-researchers? How would the use of ASL and other culturally affirmative practices support the dance-making process? How would choreography and performance techniques impact this population's well-being?

Methods

Methodology

This study employed participatory research and artistic inquiry methodologies. Participatory research involves participants in "meaningful participation in all stages of the research process" (Schneider, et al., 2004, p. 562). Also known as action or transformative research, it belongs to a family of research methodologies that simultaneously pursues action/change and research/understanding (Dick, 1999) and directly addresses the politics in research by confronting social oppression (Mertens, 2010). Participatory research assumes and intends that participants—including the researcher—will undergo a transformative experience by engaging in research (Mertens, 2010). Participants act as co-researchers (Dick, 1999; Mertens, 2010; Schneider, et al., 2004), and may be referred to as such. This research methodology has been used with adults with severe and chronic mental illness. Schneider, et al. (2004) employed a participatory research approach in investigating the relationship between individuals diagnosed with schizophrenia and their medical professionals. This approach not only contributed to the understanding of schizophrenia, but also offered the co-researchers the opportunity to overcome the isolation characteristic of their mental illness by connecting them with peers to research a topic they identified as having importance in their lives.

Artistic inquiry is a focused, systematic inquiry that involves artistic methods of collecting, analyzing, and/or presenting data; incorporates a creative research process; and is motivated and determined by the aesthetics of the researcher or researchers (Hervey, 2004). Participatory research and artistic inquiry complement each other when co-researchers engage in the art-making process. Hervey (2004) stated that this collaboration is particularly feasible "when the therapeutic goals are a psycho/social skill set that includes cooperation,

empowerment, creativity, self-esteem, relationship building, community action, assertiveness, et cetera" (p. 184). All of these goals fit well with the pre-existing treatment plans for the co-researchers involved in this study.

I chose these methodologies because I wanted to emphasize the importance of keeping Deaf culture in mind during research and clinical work, as well as the co-researchers' rights to be actively involved in their own treatment. These values are emphasized by my research site, a psychosocial rehabilitation program based on the mental health recovery model (www.mentalhealthrecovery.com). I hoped that by emphasizing their participation in this project and de-emphasizing my role as the (hearing) facilitator, my co-researchers would be empowered to create a performance piece that freely incorporated Deaf culture and any other elements that they chose. Historically, performing arts in Deaf culture have included skits, poetry, dance, storytelling, and mime with an emphasis on ASL as a part of the performance (Aquiline, 1994; Bangs, 1994; Coleman & Jankowski, 1994; Garreston, 1994; Lane, 1990).

In addition to cultural considerations, I selected participatory research and artistic inquiry because I hoped that my dance, choreography, and DMT training would make me well-suited to engaging in artistic inquiry with the co-researchers by giving me the "necessary research skills" of "accurate kinesthetic attunement, sufficient dance technique, strong observation skills, and creativity" (Hervey, 2004, p. 192) without taking the role of "expert researcher or expert artist" (Finley, 2008, p. 76). This approach aligns well with Chacian theory, which states that movement must come from the client, not the therapist (Levy, 2005). When participatory artistic inquiry is carried out in a clinical setting, the therapist-researcher must attune to the co-researchers' creative process without over-directing the art-making—just as a Chacian therapist must attune to the clients' existing movements rather than impose her own movement.

Methods

Co-researchers. The co-researchers in this study included four Deaf adults ranging in age from 45 to 55: one African-American woman, one Caucasian woman, and two Caucasian men. They were selected based on their enrollment in a day treatment program for deaf and hard-of-hearing adults with severe and chronic mental illness. Their psychiatric diagnoses included schizophrenia, psychotic disorder NOS, and major depressive disorder. Two of the co-researchers lived in semi-independent settings such as group homes, while two lived independently in the community. All four co-researchers were involved in vocational programs. The co-researchers' primary language was ASL, although they all exhibited some signs of language deprivation, including cognitive, social, and emotional deficits (Gulati, 2003).

As part of the participatory research framework, I considered myself a fifth co-researcher in this study. At the time of this study, I was 25 years old and working on my Master's thesis as part of my DMT graduate education. I am a Caucasian woman who is fluent in ASL, although English is my first language.

Procedure. The four co-researchers were presented informed consent materials in both ASL and in written English modified to fit their reading level (see Appendices B and C). They were offered the opportunity to decline participation in this study and instead join another group, although none of them selected this option. As I researcher, I attempted to maintain an awareness of research ethics at all times, considering respect for persons, beneficence, and justice (Mertens, 2010). By working in the participatory research paradigm, I was mindful of respecting the cultural norms of my clients, particularly the norms of Deaf culture. In this paradigm, beneficence and justice are conceived in terms of promoting human rights and increasing social justice (Mertens, 2010). I was committed to achieving these standards in my own research.

Once informed consent was obtained, the co-researchers met for weekly hour-long rehearsals for approximately two months. Excepting the session designated for the informed consent process and the first rehearsal, each rehearsal was structured as follows: informal check-in, review and practice previous week's material, continue choreographing piece, and verbally process the day's rehearsal.

At the beginning of the study, I invited my co-researchers to create a dance on the topic of their choosing. In order to try and shift their perceptions of me from therapist/authority figure to collaborator/co-researcher, I encouraged them to take the lead in this process. They brainstormed several ideas for the piece and eventually narrowed their choice to one selection. I then encouraged them to begin improvising and generating material around their topic of choice. As we progressed throughout the rehearsal process and my co-researchers made artistic choices, I would record important elements that we wanted to remember on the whiteboard in our rehearsal space. On this board, I also recorded their requests regarding costumes, scenery, and props.

After each rehearsal, I recorded data in a journal. As part of the participatory research process, I asked the co-researchers what type of data they wanted me to record. They requested that I record all aspects of the production (e.g., choreography, costume ideas, scenic design, etc.) so that we would remember what to work on the following week. In addition to noting information about the piece itself, I felt it was important to include my clinical impressions, as well as my reflections on my own role in the process. The finished piece—followed by a post-performance question-and-answer session—was performed at the site where the co-researchers received mental health services and recorded on digital video. We invited all clients and employees of the agency to attend the performance. Friends and family of all the co-researchers

were also invited, as well as students and faculty affiliated with my DMT master's program. One week after the performance, I facilitated a post-performance verbal processing group and recorded the co-researchers' reactions in my research journal.

Data analysis. During the rehearsals, my co-researchers and I continually analyzed and refined movement data, in order to ensure authenticity and accuracy in the final artistic product. I considered this a form of member checking. Member checking involves "seeking verification with the respondent groups"—i.e., the co-researchers—"about the constructions that are developing as a result of data collected and analyzed" (Mertens, 2010, p. 257). According to Mertens (2010), member checking helps to substantiate the credibility of qualitative research. Throughout the rehearsal process, I would pause the action and ask the co-researchers to describe and explore their movement qualities. As I asked questions about their movement and encouraged them to fully embody these movement qualities, we were able to clarify the intent behind their movement in order to present full, rich characters and accurately portray the story that the co-researchers wished to tell. This process of engaging in member checks and constantly analyzing the movement data was an important element of the participatory research framework that contributed to the credibility of this study.

After the performance, I reviewed my journal entries, as well as digital video and audio recordings of the performance and the question-and-answer session that followed. Using theme analysis, I identified the major themes that emerged throughout the rehearsal and performance process using the following parameters: the artistic process, my clinical impressions, my role as the facilitator, and culturally affirmative participatory research practices. I selected these themes based on my research questions, as well as through the organic process of qualitative,

participatory research wherein simultaneously collecting and analyzing data informs the categories of analysis and the next steps of the research process (Mertens, 2010).

Results and Discussion

As the study began, I was very excited about the social justice, oppression-confronting elements of participatory research. I hoped that my co-researchers would latch on to my suggestion of creating a piece about their experiences as Deaf adults living with mental illness who are oppressed by the majority hearing society. However, it soon became clear that the co-researchers' interests lied elsewhere. It was difficult for me to let go of this preconceived notion of what the piece would look like and to address my fears of doing participatory research "wrong." But I soon realized that the true spirit of participatory research (i.e., giving my co-researchers space to create whatever they wanted, regardless of the academic constructs of research) meant letting them select a topic that appeared less serious to me in my academic and social justice inspired worldview.

Artistic Process and Product

During the first few rehearsals, the co-researchers brainstormed ideas for the concept of the piece. Eventually, they decided to create a piece about Halloween entitled *Haunted House*. This seemed trivial to me at first; participatory research is supposed to be about effecting change and confronting oppression, not "silly" dances about holidays. Upon further reflection, I understood that this artistic choice was rooted in my co-researchers' experiences. The previous year, I had choreographed a dance for them to perform at the agency's annual holiday party. The co-researchers referred to this event as a source of pride and personal achievement. While brainstorming ideas for the piece, they mentioned this performance and then settled on the topic of Halloween, perhaps in order to replicate these positive emotions.

The co-researchers decided to structure the piece in three acts: an introductory drum section, an opening song composed in ASL, and a skit/dance entitled *Haunted House*. In the

drum section, each co-researcher chose a repeatable pattern (e.g., 4 beats, pause, 5 beats, pause, 5 beats) and took turns being the leader while the others followed. The translated lyrics of the opening song—originally conceived as the finale—were:

Happy Halloween

Welcome to our wonderful show

It might be scary!

The Halloween skit involved four characters, each named by the co-researcher playing the role: the Driver, the Woman with Binoculars, the Friendly Ghost, and the Wicked Witch. At the beginning of the piece, the Driver and the Woman with Binoculars were driving through the woods. They encountered a haunted hotel and decided to enter. The Friendly Ghost checked them in to the hotel and invited them to a dance party, where they were joined by the Wicked Witch. After the dance party, the Wicked Witch offered the others a poison apple. They refused and ran away. Enraged, the Wicked Witch flew away on her broom. For a more complete picture of the piece, please see this video. These findings addressed my first research question: What aesthetic choices would the co-researchers make in the dance-making process?

I found that the previous exposure to DMT provided an important context in which the co-researchers developed *Haunted House*: My co-researchers incorporated elements that we frequently used in DMT groups throughout my internship into the composition of *Haunted House*. Incorporating drums—especially with the mirroring rhythmic structure—was something that they stated was important to include early in the rehearsal process. The "dance party" section of the piece was choreographed using such techniques as marching in circles and lines, mirroring, and taking turns. Each of these techniques was an element that commonly appeared in

our DMT groups together. These past experiences with DMT directly informed their artistic choices.

In addition to creating dance and story elements, the co-researchers were responsible for many other aspects of the production. They painted a haunted house backdrop for the scenery and made suitcases out of cardboard for the Driver and the Woman with Binoculars. They also made requests of me regarding props and costumes. My co-researchers had a very clear vision of what they wanted and were assertive in ensuring that I procured the proper items: a jack-o-lantern that lit up, a tall black hat and long black cape for the Wicked Witch, a flowing white costume for the Friendly Ghost, and more. My co-researchers also gave me suggestions about the words and images for the publicity materials, including fliers and the program for the performance.

The performance was well-attended; over 60 people were in the audience, including staff and clients who the co-researchers have known for many years. After the performance, the co-researchers decided to host a brief question and answer session. This came as a shock to me. A few weeks earlier, I had made this same suggestion, and they unanimously and emphatically declined my offer to facilitate. The co-researchers were animated and enlivened throughout the question and answer session. They were eager to address the audiences' questions, talking about how "easy" creating the piece was and how much they enjoyed performing.

Role of the Facilitator

My second research question was: How would I, as the researcher, incorporate my experiences as a choreographer without overshadowing the contributions of my co-researchers? This was never far from my mind throughout the research process as I navigated my roles as a co-researcher and group facilitator. During the beginning stages of the research, I was very

apprehensive about what this would look like. I wanted to stay true to the spirit of participatory research and allow my co-researchers to take the lead and determine the direction of the study. However, like other PAT-oriented dance/movement therapists before me (Chace, 1954/1993c, 1958/1993a, 1958/1993d; Cook, 2008; Gates, 2006; Pavelka, 2007), I felt it difficult to let go of my preconceived notions of what I had hoped the study and the piece would look like. As the process unfolded, I learned to let go of my ideas about what participatory research should look like, what artistic inquiry should look like, and what dance should look like. I began to think of myself more as a facilitator, director, or consultant than an "expert artist" (Finely, 2008, p. 76).

However, my co-researchers did not always make this easy. They were used to seeing me as an authority figure, as someone who had led groups with them for a year already. They looked to me for ideas and leadership, but I continually encouraged them to create their own material rather than look to me for instruction or suggestions. This, I believe, gave them more agency and a sense of autonomy, empowering them and increasing their self-esteem in ways that would not have been possible if I had created a piece and taught it to them. Once they had created material, it was also my role to encourage further development of this material by asking questions about the characters they had envisioned, encouraging a fuller movement repertoire, etc.

This role was largely made possible by our existing therapeutic relationships. The therapeutic relationship between the co-researchers and me—and trust among the group as a whole—created a sufficient therapeutic environment (Gates, 2006; Pavelka, 2007) to promote their creativity and expressivity. Throughout the rehearsal and performance process, it was my responsibility to build the components of the therapeutic environment: trust, support, and validation; connection to self and others; and safety to feel vulnerable (Gates, 2006). There came a point in the rehearsal process where it no longer felt like I was leading the group, but that they

began to authentically and organically shape the piece. In order for the piece to be authentically theirs and to express what they intended to express, I—as the facilitator—had to establish the therapeutic environment.

Culturally Affirmative Participatory Research Practices

My third research question was: How would the use of ASL and other culturally affirmative practices support the dance-making process? In keeping with both participatory research practices (Dick, 1999; Mertens, 2010; Schneider, et al., 2004) and in culturally affirmative mental health care practices (Glickman, 2003; Glickman & Gulati, 2003; Oosterhous, 1985; Williams & Abeles, 2004), I tried to keep in mind the importance of affirming Deaf culture throughout the process of creating and performing the piece. However, this was a fine line for me to walk. I did not wish to impose suggestions related to incorporating elements of Deaf culture and Deaf performance to my co-researchers, fearing that this would compromise the premise of participatory research. Regardless, the co-researchers incorporated elements of Deaf culture and performance without prompting from me, although they never named them as such. For example, they went through a shift about the type of music they wished to include in the performance. During the first few rehearsals, they asked me to find them "hearing" music and translate it into ASL for them. I said that I would do it if they really wanted, but I continued to remind them that this was their performance, not mine. My intention in doing so was not to disregard their request, but rather to make available opportunities they may not have considered in order to make an empowered choice. Eventually, they decided to play drums themselves—a much more Deaf-friendly way of incorporating music because drums conduct strong vibrations that can be felt as well as heard. They also composed their own song in ASL that is meaningful in a Deaf context, rather than using a translation of hearing music.

This shift from hearing music to ASL can be understood through the lens of Deaf performing arts. Scholars of Deaf theatre such as Miles and Fant (1976) and Berson (2005) discuss a continuum between sign language theatre or outside theatre and deaf theatre or inside theater. Sign language/outside theatre is theatre performed with the hearing audience in mind, often translating classical works of English language theatre into sign language while preserving the hearing cultural norms inherent in the text. Deaf/inside theatre, however, is theatre created by and for Deaf people in ASL with a focus on Deaf issues and Deaf culture. *Haunted House* fell somewhere in between these two extremes. It has culturally Deaf elements, such as the incorporation of mime, which has a long history in Deaf storytelling and theatre (Cohen, 1989; Lane, 1990). Most importantly, culturally Deaf individuals composed *Haunted House* in ASL. The English translation for the hearing audience was primarily an afterthought, translated by me in the moment of the performance. However, the majority of the audience was hearing and the piece did not specifically address issues facing Deaf people.

Treatment Goals and Clinical Impressions

I found that the process of choreographing, rehearsing, and performing *Haunted House* addressed many of the treatment goals identified both by me and the rest of the treatment team at the co-researchers' service site, where I had been a DMT intern before beginning this research. A major treatment goal in this treatment program is to increase a client's capacity for peer support and for developing interpersonal relationships. In creating *Haunted House*, the co-researchers participated in a collaborative creative process; I observed them gradually begin to work more as a team and rely less on my directives and interventions. By engaging in the creative process, the co-researchers also demonstrated an increase in focus and present moment awareness. Finally, I observed an increased level of engagement in their treatment and services. Two of the co-

researchers, the Driver and the Woman with Binoculars, emerged as leaders during rehearsals. Both of these clients experienced depressive symptoms that caused them to isolate themselves. By becoming leaders who brainstormed ideas and directed the action of a scene, they demonstrated less withdrawn and isolative behaviors. Group attendance also increased, as did their ability to tolerate an entire hour-long group session during the course of this study.

These findings addressed my final research question: How would choreography and performance techniques impact this population's well-being? The answers to this question place this study in tradition of PAT theory research that has become increasingly prevalent over the past several years. Although my co-researchers and I did not structure our study with a specific PAT framework like that of Goldman and Larsen (2011), all of the findings listed above were in line with those of PAT-oriented dance/movement therapists like Cook (2008), Duggan (1995), and Chace (1954/1993c, 1955/1993b, 1958/1993a, 1958/1993d; Johnson, 1993).

Just as in the work of Chace (1954/1993c, 1955/1993b, 1958/1993a, 1958/1993d) and Duggan (1995), choreographing and performing their own original work appeared to empower the co-researchers and increase their self-esteem. Their pride in their work was evident during the question and answer session when they stated how "easy" creating the piece was and how much they enjoyed it. They also described feeling "proud" of the show, of themselves as individuals, and of each other in the post-performance verbal processing session. One co-researcher stated that the "many people" in the audience made her feel "nervous," but that performing for them made her feel "happy" and "good." These positive effects on their self-esteem seem to have extended beyond the performance. Many months after the conclusion of this research project, the co-researchers still discussed the piece and continued to express pride in

their achievements. They also went on to plan and choreograph a short Christmas-themed performance with minimal assistance from me or any other staff member.

The co-researchers increased their range of authentic emotional expression (Chace, 1954/1993c, 1955/1993b, 1958/1993a, 1958/1993d; Cook, 2008) and feeling identification by developing fictional characters. Each character reflected, at least to some degree, the personalities and clinical issues of each co-researcher. The Wicked Witch, for example was a client striving to manage her anger. By creating a character who experienced anger within the context of a fictional piece, she was able to express her angry feelings in a safe, non-threatening environment where she needed not fear punishment or social ostracism. Moreover, expressing her anger via performance provided her with an outlet that is both socially acceptable and socially valued. It is interesting to note that, during rehearsals, the Wicked Witch expressed more authentic anger over a longer period of time than in the final performance. During the final performance, she "rushed" her big scene and did not fully immerse herself in becoming angry with those who had rejected her poison apple. I believe that enacting her anger, even in a fictional context, may have been too vulnerable an action to perform in front of a large audience. However, I also believe that it was cathartic and reparative for her to be able to authentically express her anger during rehearsals.

In order to help my co-researchers develop their characters, we spent time analyzing these characters through the lens of Laban Movement Analysis, specifically within the Effort category. I chose to work with Effort because this category describes the dynamic qualities of movement (Bartenieff, 1980/2002; Moore, 2009). Examining the Effort qualities of the characters' movements addressed the goal of expanding movement repertoire in order to fully embrace the expressive possibilities of their movement. Having worked with the co-researchers

for nearly a year before the onset of this project, I had observed that they tended to draw upon Pre-Efforts (Kestenberg-Amighi, Loman, Lewis & Sossin, 1999) rather than full Efforts—meaning that the expressive qualities of their movements were less dynamic and fully developed. Through exploring Effort qualities, we decided that the Friendly Ghost would move with lightness, that the Driver and Woman would approach the haunted house slowly, and so on. This allowed the co-researchers to embody and inhabit their characters in a way that best met their artistic vision.

As the piece developed, it became clear to me that each co-researcher was creating a character that mirrored his or her own Effort qualities. By helping them fully embody their preferred Effort qualities, I hoped to affirm the positive attributes associated with their movement preferences. For example, the Friendly Ghost who moved with lightness and little attention to space has often been chastised for being inattentive. Although this inattentive quality proved to be an asset for the purpose of character development, it was not always an effective way of relating and coping in his daily interactions. However, *Haunted House* showcased his natural movement qualities in such a way that allowed the audience to witness and applaud the way he moved through the world. I believe that this finding speaks to the power of choreography and performance within the therapeutic environment (Gates, 2006; Pavelka, 2007). Rather than being rebuked or asked to change, the Friendly Ghost had his preferred Effort qualities witnessed, supported, and validated by his co-researchers and by the audience. Although none of the co-researchers used these terms, they did describe how "happy" and "surprised" they were with the large audience that came to watch them perform. I believe that being witnessed in their performance of *Haunted House* had a validating, therapeutic impact on them.

Summary

The purpose of this study was to investigate the use of DMT, choreography, and performance techniques with Deaf adults with severe and chronic mental illness through participatory artistic inquiry. In making aesthetic choices about *Haunted House*, the co-researchers incorporated familiar elements of DMT, composed their own script in ASL, and created their own production elements such as props and scenery. As a co-researcher and facilitator, my role was to let go of my preconceived notions of the creative process, to encourage my co-researchers to develop their own material, and to establish and maintain the therapeutic environment. Culturally affirmative practices supported incorporating Deaf culture into the creative process, as evidenced by the co-researchers integrating ASL and mime into the piece. As my co-researchers developed *Haunted House*, I was able to observe how choreography and performance techniques may impact Deaf adults with severe and chronic mental illness. In the context of the therapeutic environment, these techniques increased collaboration and peer support, present moment focus, self-esteem, range of authentic emotional expression, and range of expressive movement. Choreographing and performing *Haunted House* in the context of the therapeutic environment played a crucial role in producing these effects by validating and supporting the co-researchers' work, helping them to feel safe in expressing themselves and showing the final product to an audience.

This research augments the existing body of literature. It is one of the few studies involving creative arts therapy in the field of mental health and Deafness, and the first study investigating DMT with this population in over a decade. This study also supports the small but growing body of PAT literature. PAT research in a clinical setting is rare, and this is the first known example of researching choreography and performance with Deaf adults with severe and chronic mental illness.

However, this study is limited. The very small sample size of four co-researchers makes it difficult to generalize the results. This study may also be limited in its methodological foundation. Throughout the research process, I often questioned whether or not my co-researchers and I were performing "pure" participatory research (Dick, 1999; Mertens, 2010; Schneider, et al., 2004). In ideal participatory research, co-researchers will be involved in creating and implementing all facets of the research design. In this study, my co-researchers were not interested in the more academic components of research. The fact that they were involved in research at all was much less important to them than the fact that they were creating an enjoyable piece about Halloween. Although they were involved in data collection and analysis as we developed and refined *Haunted House*, they never read my research journal or interacted with the data in a structured, formalized way. This may have, in part, been due to a lack of understanding of the research process and a decreased capacity for abstract thinking due the consequences of language deprivation. Even though this study does not fall neatly within the parameters of "pure" participatory research, I believe that its collaborative participatory nature is strong enough for it to be considered participatory research. This is particularly evident when considering the relationship between participatory artistic inquiry and PAT. A study that encourages co-researchers to engage in a creative process and perform a piece inherently demands a high level of participation in the research process.

I did not set out to do PAT with my co-researchers. That is to say, I did not introduce a specific PAT framework (Goldman & Larsen, 2011) or intentionally address the aspects of the therapeutic environment (Gates, 2006; Pavelka, 2007). However, the results of this study clearly show commonalities with existing PAT theory and research. PAT is an under-researched topic in DMT. This study is one of the few examples of PAT in a clinical setting. More research is

needed in this area of study in order for our profession to demonstrate the implications of choreography and performance with Deaf adults with severe and chronic mental illness and other populations. For example, it may be beneficial to replicate this study with a larger sample size in order to increase its generalizability. This will make a stronger link between PAT theory and the application of PAT in a clinical setting. Such research may be particularly feasible in recovery-oriented treatment settings that encourage active participation in goal setting and treatment planning (www.mentalhealthrecovery.com).

In addition to PAT applications, more research is needed to understand DMT with Deaf adults who have severe and chronic mental illness. How do other DMT and other body-based interventions impact this population (e.g., Chacian DMT, mindfulness practices, etc.)? How can dance/movement therapists address Deaf culture and disability culture in DMT sessions? What are the phenomenological experiences of Deaf adults with mental illness in DMT sessions? Addressing these and other research questions will begin to address the substantial lack of research involving DMT with this population.

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Appendix A

Definition of Terms

American Sign Language (ASL)

The signed language utilized by Deaf persons in the United States. It is grammatically and syntactically distinct from the English language (Humphries, Padden, & O'Rourke, 1994; Isenhath, 1990; Stokoe, 1993; Stokoe, Casterline & Cronenberg, 1976; Valli & Lucas, 1995).

Artistic Inquiry

A focused, systematic inquiry with the following characteristics: artistic methods of collecting, analyzing, and/or presenting data; utilizes a creative research process; and is motivated and determined by the aesthetics of the researcher or researchers (Hervey, 2004).

Cultural Affirmation

Service providers who are culturally affirmative have "cultural competence, relevant self-awareness, and special knowledge and skills" (Glickman & Gulati, 2003, p. xi).

D/deaf

The capital letter "D" indicates cultural Deafness, while a lower case "d" notes only audiological capacity without reference to membership in a cultural group (Williams & Abeles, 2004).

Language deprivation

Language deprivation may occur in deaf/hard-of-hearing individuals when they are not sufficiently exposed to language before the end of the "critical period" (Gulati, 2003, pp. 42-43), generally believed to end at approximately age six. According to Gulati (2003) language deprivation may result in a variety of deficits in social skills, emotional development, and complex intellectual functions such as abstract thought.

Participatory research

Research that involves participants in "meaningful participation in all stages of the research process" (Schneider, et al., 2004, p. 562). Also known as action or transformative research, it belongs to a family of research methodologies that simultaneously pursue action/change and research/understanding (Dick, 1999) and directly address the politics in research by confronting social oppression (Mertens, 2010).

Performance as therapy

The process of creating a dance "for the purposes of performance involving dance/movement therapy techniques within a therapeutic environment" (Gates, 2006, p. 5). The therapeutic environment consists of trust, support, and validation; connection to self and others; and safety to feel vulnerable (Gates, 2006, p.5).

Severe and chronic mental illness

A "clinically important" collection of behavioral and/or psychological symptoms that causes an individual distress, disability, or the increased risk of suffering pain, disability, death, or the loss of freedom (Morrison, 2001, p. 8). In order to classify a mental illness as "severe," the individual must have "many more symptoms than the minimum criteria specify, or some symptoms are especially severe, or functioning in society or at work is especially compromised" (p. 5). Chronicity is intended to mean that the individual continues to experience symptoms throughout his or her life (Morrison, 2001, p. 143).

Speech-reading

Often called reading lips, speech-reading is a complex and sometimes exhausting skill that involves analyzing the mouth, eyes, eyebrows, facial expression, and associational cues such

as objects and the surrounding environment in order to discern the speaker's message (Moore & Levitan, 1993).

Appendix B

Columbia COLLEGE CHICAGO

Informed Consent Form

Consent Form for Participation in a Research Study

Title of Research Project: Choreography and Performance With Deaf Adults with Mental Illness: Culturally Affirmative Participatory Research
Principal Investigator: Sondra Malling
Faculty Advisor: Jessica Young
Chair of Thesis Committee: Laura Downey

INTRODUCTION
You are invited to participate in a research study to choreograph and perform a dance based on your experience as a deaf person in the NAME OF PROGRAM. This consent form will give you the information you will need to understand why this study is being done and why you are being invited to participate. It will also explain what you need to do to participate and any known risks, inconveniences or discomforts that you may have while participating. Please take time to think this over. Please ask questions now and at any time. If you decide to participate, you will be asked to sign this form and it will be a record of your agreement to participate. This process is called 'informed consent.' You will get a copy of this form to keep.

You are being asked to participate because you are a member of the NAME OF PROGRAM, NAME OF SITE and involved in a dance/movement therapy group.

PURPOSE OF THE STUDY
The purpose of this research study is to make a dance created by the NAME OF PROGRAM members. You will choose the topic of the dance and perform it for an audience at the NAME OF SITE. You will choose the message you want to tell the NAME OF SITE in your dance.

PROCEDURES
- Attend weekly dance/movement therapy groups at the NAME OF SITE. Each session will last for one hour.
- Create a dance with the other NAME OF PROGRAM members and me.
- Practice the dance until it is ready to be performed.
- Perform the dance at the NAME OF SITE. The dance will be recorded on a DVD video that will be put on the Columbia College Chicago library website. After the performance, you are finished with the study and will not be contacted by me in the future.

POSSIBLE RISKS OR DISCOMFORTS
It will take time to finish the study. You will be required to dance and move safely and comfortably. You may feel upset if you miss many rehearsals and can't be in the performance. I will try my best to make sure that you can be in the dance. If you can't perform onstage, you can help in another way like giving programs to the audience and setting up the stage.

POSSIBLE BENEFITS
The possible benefits of being in this study include creating a dance that you can be proud of and show to everyone at the NAME OF SITE. I hope that your participation in this study will give NAME OF SITE staff and other mental health professionals the opportunity to learn about your experience as a deaf person with mental illness.

CONFIDENTIALITY
The following procedures will be used to protect the confidentiality of your information:
1. I will keep all study records locked in safe place.
2. All computer files containing personal information will be password protected.
3. Your name will not be connected to the study to help protect your identity.
4. Only I will have access to the original data.
5. At the end of this study, I may publish what we learn in this study. You will not be identified in any publications or presentations by name.
6. The person who makes the video will not give it to anyone but me.
7. The final recording will be submitted to Columbia College Chicago, put on the library website, and may be shown in future presentations.

RIGHTS
Being a research participant in this study is your decision. You may choose to withdraw from the study at any time with no punishment. You may also refuse to participate at any time with no punishment.

Take time to think about it before you make a decision. I will be happy to answer any questions you have about this study. If you have more questions about this project or if you have a problem with the study, you can contact the principal investigator Sondra Malling at XXX-XXX-XXXX (text and voice) or the faculty advisor Jessica Young at (XXX) XXX-XXXX (voice only). If you have any questions concerning your rights as a research subject, you can contact the Columbia College Chicago Institutional Review Board staff (IRB) at XXX-XXX-XXXX.

COST OR COMMITMENT
You will need to come to dance/movement therapy group for one hour every week in order to create and practice the dance. These will take place from June until September. In September, you will need to come to the final recording of the performance. All practices and the performance will be at the NAME OF SITE.

PARTICIPANT STATEMENT

This study has been explained to me. I volunteer to take part in this research. I have had opportunity to ask questions. If I have questions later about the research or my rights as a research participant, I can call or email the people on this paper. I understand that I may withdraw from the study or refuse to participate at any time with no punishment. I will get a copy of this consent form.

_____	_____	_____
Participant/Parent/ Guardian Signature:	Print Name:	Date:

Relationship (only if not participant): _____

_____	_____	_____
Signature of Person Obtaining Consent	Print Name:	Date:

_____	_____	_____
Principal Investigator's Signature	Print Name:	Date

Appendix C

Columbia
COLLEGE CHICAGO
INNOVATION IN THE VISUAL, PERFORMING, MEDIA, AND COMMUNICATION ARTS
600 S. Michigan Avenue, Chicago, IL 60605

Release of Digital Representation to the World Wide Web
As Part of a Master's Thesis
(Revised Version)

I give Columbia College Chicago the permission to:

- Put sounds, visual, pictures, video of me and/or my artwork on the internet as part of Sondra Malling's project titled *Choreography and Performance With Deaf Adults With Mental Illness: Culturally Affirmative Participatory Research.*
- I understand that my privacy in this project cannot be fully protected if I give permission for pictures/video of me to be put on the internet for this project and give up this right.
- I understand that my name and other private information will not be put on the internet with pictures/video of me, except if I give permission.
- I am willing to give permission and I can decide for myself if putting picture/video of me on the internet is OK or not.
- I give up the pictures/video of myself forever to staff at Columbia College Chicago. I will not sue Columbia College Chicago. My family and advocates will not sue Columbia College Chicago.

This release is governed in accordance with the laws of the State of Illinois.

Name

Address

Signature Date

Witness Signature